

Table 1: PMTCT Options and Recommendations by Clinical Scenario (page 1 of 3)

Scenario	Mother	Infant	Comments
A: Non-pregnant woman who needs HAART for her own health and may become pregnant	First line regimen per Chapter IV : (AZT or d4T) + 3TC + NVP	N/A	<ul style="list-style-type: none"> - Efavirenz should be avoided in women who may become pregnant due to potential teratogenicity - issues of potential resistance, adherence, and prior treatment regimens should be considered in the design of the woman's HAART regimen, as detailed in Chapter IV. - Demonstrated efficacy of AZT in reducing risk of MTCT favours its inclusion in HAART regimens of women who may become pregnant; however, if poorly tolerated or unavailable, another NRTI (e.g. d4T) can be used instead - a significantly higher risk of liver toxicity is seen in women with CD4 counts over 250 who initiate NVP-based HAART, hence NVP should be avoided or used with caution in these women; see Chapter IV for more details
B: Woman who is already receiving HAART at the time she becomes pregnant	<ul style="list-style-type: none"> - Do not discontinue HAART; continue during pregnancy, labour and post-partum - If she is on EFV and within the 1st trimester, substitute a PI or NVP; - avoid combination of ddI + d4T in pregnancy 	Three options: AZT for one week; ¹ <i>or</i> AZT for one week* plus SD NVP; <i>or</i> SD NVP	<ul style="list-style-type: none"> - If receiving efavirenz-based therapy and is in first trimester of pregnancy, efavirenz should be discontinued and replaced by another drug; See text - so long as mother continues to receive HAART during pregnancy, AZT alone can be administered to the infant; this strategy is associated with an MTCT rate of <2% in US and European studies - if mother is on a regimen containing ddI <i>and</i> d4T, would substitute a different NRTI for one of these agents due to excess toxicity associated with this combination in pregnancy
C: Pregnant woman not on HAART who now requires HAART per local guidelines	<ul style="list-style-type: none"> - Initiate HAART: First line regimen per Chapter IV, ideally AZT + 3TC + NVP - continue HAART during labour and post-partum 	Three options: AZT for one week;* <i>or</i> AZT for one week* plus SD NVP; <i>or</i> SD NVP	<ul style="list-style-type: none"> - issues of potential resistance, adherence, and prior treatment regimens should be considered in the design of the woman's HAART regimen, as detailed in Chapter IV - treatment should not be delayed if mother requires it for her own health and the drugs can be initiated during the first trimester - A PI is preferred over NVP in women with CD4 counts over 250 because a significantly higher risk of liver toxicity is seen in women with CD4 counts over 250 who initiate NVP - Demonstrated efficacy of AZT in reducing risk of MTCT favours its inclusion in HAART regimens of pregnant women; however, if poorly tolerated or unavailable, another NRTI (e.g. d4T) can be used instead

¹ Extend infant's course of AZT to four weeks if the mother received less than four weeks of ART prior to delivery.

Scenario	Mother	Infant	Comments
D: Pregnant woman who does not require HAART for her own health <i>Two preferred options</i>	Option 1. AZT starting at 28 weeks or as soon as feasible thereafter; continued during labour, with or without SD NVP at onset of labour <i>(see Comments)</i>	AZT for one week plus SD NVP*	- in order to reduce risk of NVP resistance, maternal dose of SD NVP may be omitted if mother receives at least four weeks of AZT immediately prior to delivery and the infant is given single-dose NVP immediately at birth. Alternatively, a seven day 'tail' of AZT/3TC can be given to the mother following delivery if she received SD NVP (<i>see Appendix C for details</i>)
	Option 2. HAART; preferred regimen: AZT + 3TC + (PI or NVP); continue during labour; discontinue following delivery	<u>Three options:</u> AZT for one week;* <i>or</i> AZT for one week* plus SD NVP; <i>or</i> SD NVP	
Scenario D continued: four alternative options	Option 3. AZT starting at 28 weeks or as soon as feasible thereafter; continued during labour	AZT for 1-6 weeks	- Associated with a significant reduction in the risk of PMTCT, but not as effective as options 1 or 2 above; See text
	Option 4. SD NVP at onset of labour	SD NVP	- Associated with a significant reduction in the risk of PMTCT, but not as effective as options 1 or 2 above; See text - Consider giving seven day 'tail' of AZT/3TC to mother following delivery to reduce risk of NVP resistance (<i>see Appendix C for details</i>).
	Option 5. AZT + 3TC starting at 32 weeks or as soon as possible thereafter, and continued during labour	AZT + 3TC for 1 week	- Associated with a significant reduction in the risk of PMTCT, similar efficacy as AZT + SD NVP but more complex; See text
	Option 6. AZT + 3TC starting at 32 weeks or as soon as feasible thereafter, continued during labour, with SD NVP	SD NVP plus AZT/3TC for one week	- Associated with a significant reduction in the risk of PMTCT, similar efficacy as AZT + SD NVP but more complex; See text - Consider giving seven day 'tail' of AZT/3TC to mother following delivery to reduce risk of NVP resistance (<i>see Appendix C for details</i>).

¹ Extend infant's course of AZT to four weeks if the mother received less than four weeks of ART prior to delivery.

Scenario	Mother	Infant	Comments
E: HIV-infected woman without any prenatal ART who presents in labour	Option 1: SD NVP + AZT immediately	SD NVP plus AZT for four weeks	<ul style="list-style-type: none"> - Mother must be assessed postpartum for need for ART and enrolled into appropriate HIV care - Consider giving seven day 'tail' of AZT/3TC to mother following delivery to reduce risk of NVP resistance (<i>see Appendix C for details</i>).
	Option 2: AZT/3TC immediately	AZT/3TC for 7 days	<ul style="list-style-type: none"> - Continue AZT/3TC for the mother for an additional week if she is breastfeeding - Mother must be assessed postpartum for need for ART and enrolled into appropriate HIV care
	Option 3: SD NVP immediately	SD NVP	<ul style="list-style-type: none"> - If mother delivers within 2 hours of receipt of NVP, give the infant NVP as soon as possible, plus one week of AZT if available - Mother must be assessed postpartum for need for ART and enrolled into appropriate HIV care - Consider giving seven day 'tail' of AZT/3TC to mother following delivery to reduce risk of NVP resistance (<i>see Appendix C for details</i>).
F: Woman of unknown HIV status who presents in labour	Test for HIV (ideally using rapid test); if positive, manage as scenario E	If mother tests HIV-positive, but did not receive intrapartum ART, see scenario G below	<ul style="list-style-type: none"> - If mother tests positive for HIV infection, she must be assessed postpartum for need for ART and enrolled into appropriate HIV care
G: HIV-infected woman who has received no ART for PMTCT, either prepartum or during labour	N/A	SD NVP as soon as possible, plus 4 weeks of AZT	<ul style="list-style-type: none"> - SD NVP unlikely to be useful for infants if not given within 3 days of birth. - Mother must be assessed postpartum for need for ART and enrolled into appropriate HIV care